2006 GPRA REPORTING INSTRUCTIONS

RPMS and Non-RPMS Users (Urban Programs)

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Statement of Purpose

Dear Program Administrator:

The purpose of this letter is to request your assistance in collecting the Government Performance and Results Act (GPRA) data for Fiscal Year 2006.

As you may know, GPRA can help in monitoring and improving quality patient care in your facility. The basic questions that GPRA data can answer are straightforward: "Are we doing those things that we agreed were important for maximizing the health of our Active clinical patients?" and "Are there ways that we could improve the overall health status of our patient population?" It is important to remember that your facility is most likely already reporting diabetes care data, childhood and elder care immunization data, as well as cervical and breast cancer screening data (if reporting on UDS). Therefore there will only be an additional 5 measures (depression screening, intimate partner violence, FAS screening, tobacco cessation, and childhood weight control) that will need to be tracked through this process.

The staff at your facility will be asked to participate in the reporting process. While this process may seem overwhelming at first, many providers have found that participating in the GPRA reporting process provides a review of standards of care for a broad range of disease categories and identifies disease trends at their facility. Through the reporting process, providers often gain a better idea of what changes they can make to improve the outcome for their patients who suffer from devastating and sometimes preventable diseases.

Once the reporting process is completed, the data should be forwarded on to the National GPRA data repository at the California Area Office in addition to your Area GPRA coordinator. Since GPRA requires that reported performance data must be valid and verifiable, you will need to maintain a copy of the summary report and all supporting documentation (i.e. queries, including logic for each measure) for your records. This file will be useful in the event of an audit and will also assist your staff with future reporting requirements.

Your Area GPRA coordinator can assist you in obtaining National and Area GPRA reports and comparison data. In addition, your Area GPRA coordinator can assist you in identifying program strengths and deficiencies. Facilities are encouraged to review the summary report and recommendations in a team setting, establish priorities together, and develop an action plan with a timetable for re-evaluation.

On behalf of the National and California GPRA team, we thank you and your staff for your participation in the GPRA process.

Preface

Welcome to GPRA 2006! The Government Performance and Results Act (GPRA) requires Federal agencies to demonstrate that they are using their funds effectively toward meeting their missions. The law requires agencies to have a 5-year Strategic Plan in place and to submit Annual Performance Plans describing specifically what the agency intends to accomplish toward those goals with their annual budget. Every year, the agency reports on how the agency measured up against the performance targets set in the Annual Performance Plan.

The Indian Health Service tracks and reports on GPRA clinical measures relating to diabetes care, cancer screening, immunization, and other preventative health measures. Other GPRA measures include non-clinical measures relating to technology and data improvement, quality of care, and infrastructure.

Please take the time to read carefully through the following information for a brief summary of this year's changes followed by general directions. More specific instructions for any of the steps appear in subsequent sections.

Introduction

RPMS vs. Non-RPMS

Facilities that are currently running RPMS are able to report on any or all of over 200 clinical performance measures, representing 44 clinical topics. Each year, an updated version of CRS software is released to reflect changes in and additions to clinical performance measure definitions. Due to these continuous changes, it is critical to ensure the most up to date software is in place prior to the GPRA reporting period. If your facility is currently running RPMS please see the subsequent section (*GPRA reporting instructions for RPMS users*) for the appropriate reporting instructions. For additional information on CRS software installation and logic please reference the following: http://www.ihs.gov/cio/crs/index.asp

Facilities that do not run RPMS clinical software will have to submit GPRA data using the provided Excel template (*2006 GPRA reporting template*). For facilities that wish to run their audits through electronic queries, it is imperative to run simultaneous manual and e-audits and compare results before submitting data. The results from the manual and e-audit should be quite similar. If the results of one or more of the elements are significantly different, an investigation into the reasons for the divergence needs to be undertaken. Once the differences are resolved, the two auditing methods should yield analogous results and the electronic query audits can provide validated results. If your facility is currently running a Non-RPMS software package, please see the subsequent section (*GPRA reporting instructions for Non-RPMS users*) for the appropriate reporting instructions.

GPRA Reporting Instructions for RPMS users

Note: 2006 GPRA report is due No Later Than August 15, 2006 (using CRS 6.1)

These instructions provide specific information about the menu options you must choose in order to generate the correct output for this reporting requirement. (Please note that you will not be able to generate the most current reportable data unless you have installed CRS Version 6.1. Previous CRS versions will run a GPRA report, but will provide outdated information for purposes of GPRA reporting).

To run your GPRA "Annual" report:

1. At the IHS/RPMS Clinical Reporting System menu, select CI06 (CRS 2006).

```
**********************************
** IHS/RPMS Clinical Reporting System (CRS) **
**********************************
Version 6.1
DEMO SITE
CI06 CRS 2006 ...
CI05 CRS 2005 ...
GP04 GPRA+ FY04...
GP03 GPRA+ FY03...
GP02 GPRA+ FY02...
Select IHS Clinical Reporting System (CRS) Option: CI06 CRS 2006
```

2. At the CRS Reports Menu, select RPT (Reports).

```
**********************************
** IHS/RPMS CRS 2006 **
** Clinical Reporting System **
**********************************
Version 6.1
DEMO SITE
RPT Reports ...
SET System Setup ...
AO Area Options ...
Select CRS 2006 Option: RPT Reports
```

3. At the Reports Menu, select NTL (National GPRA Reports).

```
**************************
** IHS/RPMS CRS 2006 **
** Reports Menu **
**************************
Version 6.1
DEMO SITE
NTL National GPRA Reports ...
LOC Reports for Local Use: IHS Clinical Indicators ...
OTH Other National Reports ...
Select Reports Option: NTL National GPRA Reports
```

4. At the National GPRA Reports menu, select GP (National GPRA Report).

```
**********************************
** IHS/RPMS CRS 2006 **
** National GPRA Reports **
**********************************
Version 6.1
DEMO SITE
GP National GPRA Report
LST National GPRA Report Patient List
Select National GPRA Reports Option: GP National GPRA Report
```

5. At the next screen, if the message is "The following taxonomies are missing or have no entries", you can exit by typing a (^) at any prompt until you return to the main menu; follow the directions for taxonomy setup in the CRS User Manual. If the message All taxonomies are present appears, press ENTER.

IHS 2006 National GPRA Report
This will produce a National GPRA report for a year period you specify.
You will be asked to provide the Community taxonomy to determine which Patients will be included. This report will be run for the time period July 1, 2005 through June 30, 2006 with a baseline period of July 1, 1999 through June 30, 2000. This report will include beneficiary population of American Indian/Alaska Native only.

Do not export this data to the Area office. If you answer yes at the export prompt, a report will be produced in export format for the Area Office to use in Area aggregated data. However, because the Urban data will be separate from all other reports submitted annually, the data from your facility needs to be forwarded separately (via e-mail) to the GPRA National Data repository, located at the California Area Office, as well as your Area GPRA coordinator.

Checking for Taxonomies to support the National GPRA Report...
All taxonomies are present.
End of taxonomy check. PRESS ENTER:

6. Type the name of your community taxonomy. (If you don't know the Community taxonomy, type two question marks (??) to see the entire list; for GPRA reporting purposes, the community should be the same as the site CHSDA, except in Oklahoma.)

7. Type N at the "Do you wish to export this data to Area?" prompt.

Specify the community taxonomy to determine which patients will be included in the report. You should have created this taxonomy using QMAN or the Taxonomy Setup option.

```
Enter the Name of the Community Taxonomy: GPRA Community
Your HOME location is defined in Site Parameters as: HOME asufac: 123456
Do you wish to export this data to Area? // NO
```

8. At the next prompt, select D (this will create a delimited file that will be easily transferable to the California Area Office).

SUMMARY OF NATIONAL GPRA REPORT TO BE GENERATED
The date ranges for this report are:
Reporting Period: Jul 01, 2005 to Jun 30, 2006
Previous Year Period: Jul 01, 2004 to Jun 30, 2005
Baseline Period: Jul 01, 1999 to Jun 30, 2000
The COMMUNITY Taxonomy to be used is:
The HOME location is: HOME 123456

Please choose an output type. For an explanation of the delimited file please see the user manual.

Select one of the following:
P Print Report on Printer or Screen
D Create Delimited output file (for use in Excel)
B Both a Printed Report and Delimited File

Select an Output Option: P// D Create Delimited output file

DEVICE: HOME// 0;P-OTHER80 VT Right Margin: 80//

9. Select output type: S// FILE - delimited output will be written to a file in pub

You have selected to create a delimited output file. You can have this output file created as a text file in the pub directory OR you can have the delimited output display on your screen so that you can do a file capture. Keep in mind that if you choose to do a screen capture you CANNOT Queue your report to run in the background!!

Select one of the following:
S SCREEN – delimited output will display on screen for capture
F FILE – delimited output will be written to a file in pub

Select output type: S// f FILE – delimited output will be written to a file in pub. Enter a filename for the delimited output (no more than 40 characters): FacilityName2006
When the report is finished your delimited output will be found in the D;\PUB directory. The file name will be FacilityName2006.txt

*A GPRANT file will be created in addition

NOTE: When you are finished reviewing your report for accuracy, select the file in the designated directory as an e-mail attachment and send to the California Area Office **as well as your Area GPRA coordinator.**

TO: Janae Price – Janae.price@ihs.gov Cc: Elaine Brinn – Elaine.brinn@ihs.gov

GPRA Reporting for Non-RPMS Users

Electronic Queries

***Note: 2006 GPRA report is due No Later Than August 15, 2006**

Data Collection

1. Run a list of your ***GPRA user population*** (based on definition provided on page 13) to determine all patients that should be included in the review process.

2. Once you have tracked identified your GPRA user population files, sub-categorize those patients into their appropriate denominator definition for each specific measure or group of measures (see Table 1, column B).

3. Once you have identified all of the active patients in that measure(s), query only those patients that fit the criteria described by the numerator logic of that measure.

4. Continue this process until you have queried all appropriate patients for each measure.

**As noted previously, all electronic queries and subsequent data should be saved so that the information submitted can be validated in the event of an audit review.*

Data Entry

1. For manual tabulation of data please use the Electronic Query Cheat Sheet (Table 1). This method will have to be transferred to the ***2006 GPRA reporting template*** before it can be submitted to the California Area Office.

2. For electronic tabulation of data please use the Excel Template (***2006 GPRA reporting template***) provided.

Data Submission

1. Once you have entered your data into the 2006 GPRA reporting template, save the file as: FacilityName2006.xls

2. Open e-mail and send file as an attachment to the California Area Office **as well as your Area GPRA coordinator** with subject title (FacilityName 2006 GPRA Report) to:

   To: Janae.price@ihs.gov Cc: Elaine.brinn@ihs.gov

Manual Chart Reviews

In an effort to maintain similar standards for all Urban programs, facilities that perform manual chart reviews are strongly encouraged to audit ***100%*** of their patient population. However, in the event that your facility is unable to audit all charts you will need to follow the subsequent guidance relating to sample size and reporting of population samples.

***Note: 2006 GPRA report is due No Later Than August 15, 2006**

100% Chart Review for GPRA reporting

Data Collection

1. Run a list of your ***GPRA user population*** (based on definition provided on page 13) off of your patient registration data to determine all patients that should be included in the review process.

2. Once you have tracked down the records of all GPRA users, sort the records by GPRA denominator group, (i.e. separate out all active diabetic patients).

3. Record the number of patients in that group (denominator). [Column D-Table1]

4. Once the records are separated review each chart for the appropriate numerator logic (e.g. documented A1c, etc). ***See Attachment: Manual Chart Review Sheet***

**Make sure you keep the Manual Chart Review Sheet with each individual record throughout the review process as some patients will be reviewed for more than one group.*

5. After completion of the first group, continue the process for subsequent groups (active clinical patients 65+, female active clinical patients 15-44, active clinical patients 18+, etc.) until you have reviewed all charts for each measure.

Data Entry

3. From each Manual Chart Review Sheet, tabulate the total number of patients in the numerator and denominator of each group and transpose the data onto the Electronic Query Cheat Sheet (Table 2).

4. Once the data collection process is complete (Electronic Query Cheat Sheet), transfer the data to the Excel Template (***2006 GPRA reporting template***) provided.

Data Submission

6. Once you have entered your data into the 2006 GPRA reporting template, save the file as: FacilityName2006.xls

7. Open e-mail and send file as an attachment to the California Area Office **as well as your Area GPRA coordinator** with subject title (FacilityName 2006 GPRA Report) to:

   To: Janae.price@ihs.gov Cc: Elaine.brinn@ihs.gov

**Note: All manual review sheets and subsequent data should be saved so that the information submitted can be validated in the event of an audit review.*

Population sampling for GPRA reporting

Data Collection

1. **Determine your sample size**. *See Table 2*
2. **Randomly select charts**:

The systematic random sampling technique will provide the best representative sample for audit. This is done in the following fashion: Suppose you need to select 69 charts from a registry list of 1000 patients. First, divide 1000 by 69, which yields the number 14.4. You now know that you must select one chart out of fourteen.

However, don't automatically start with the first person. Use any method of random chance to determine which one of the first 14 people on the list should be selected. Use your imagination! Number 14 pieces of paper with 1 through 14 and have someone draw one, or simply ask someone to pick a number between 1 and 14. Then use that number to select your first name for chart audit.

Proceed through the entire list, selecting every 14th person on the list. Please note that it is important to track down the charts which are missing from Medical Records as these are likely to belong to patients who have been seen recently and have high compliance with the Standards of Care.

3. Once you have tracked down all of the records for that GPRA measure or group of measures, **review each chart** for the appropriate numerator logic (e.g. documented A1c, etc). ***See Attachment: Manual Chart Review Sheet***

**Make sure you keep the Manual Chart Review Sheet with each individual record throughout the review process as some patients will be reviewed for more than one group.*

4. After completion of the first group, **continue the random sampling process** for subsequent groups (active clinical patients 65+, female active clinical patients 15-44, active clinical patients 18+, etc.) until you have reviewed all charts for each measure.

Data Entry

5. From each Manual Chart Review Sheet, **tabulate the total** number of patients in the numerator and denominator of each group and transfer the data onto the Electronic Query Cheat Sheet (Table 2).

6. Once the data collection process is complete (Electronic Query Cheat Sheet), **transfer the data to the Excel Template** (***2006 GPRA reporting template***) provided.

Data Submission

7. Once you have entered your data into the 2006 GPRA reporting template, save the file as: FacilityName2006.xls
8. Open e-mail and send file as an attachment to the California Area Office **as well as your Area GPRA coordinator** with subject title (FacilityName 2006 GPRA Report) to:

   To: Janae.price@ihs.gov Cc: Elaine.brinn@ihs.gov

**Note: All manual review sheets and subsequent data should be saved so that the information submitted can be validated in the event of an audit review.*

Table 1: Electronic Query Cheat Sheet

SAMPLING METHOD (please circle the appropriate method): 100% RANDOM SAMPLING

A. GPRA Measure	B. Denominator (logic cross reference)	C. # Patients in Numerator	D. # Patients in Denominator
Diabetes Dx Ever	GPRA User Population (see page 13)		
Documented HbA1c	Active Diabetic Patients (see page 14)		
Poor Glycemic Control	Active Diabetic Patients (see page 14)		
Ideal Glycemic Control	Active Diabetic Patients (see page 14)		
Controlled BP <130/80	Active Diabetic Patients (see page 14)		
LDL Assessed	Active Diabetic Patients (see page 14)		
Nephropathy Assessed	Active Diabetic Patients (see page 14)		
Influenza 65+	Active Clinical Patients ages 65 or older (see page 15)		
Pneumovax 65+	Active Clinical Patients ages 65 or older (see page 15)		
Pap Smear Rates	Female Active Clinical Patients ages 21-64 w/out documented history of Hysterectomy (see page 16)		
Mammogram Rates	Female Active Clinical Patients ages 52-64 w/out doc hx of bilateral mastectomy or 2 separate unilateral mastectomies (see page 16)		
FAS Prevention	Female Active Clinical Patients ages 15-44 (see page 17)		
DV/IPV Screening	Female Active Clinical Patients ages 15-40 (see page 17)		
BMI (Childhood Weight Control)	Active Clinical Patients ages 2-5 for whom BMI could be calculated (see page 18)		
Tobacco Cessation	Active Clinical Patients identified as current tobacco users (see page 19)		
Childhood Immunization	Active Clinical Patients ages 19-35 months (see page 19)		
Depression Screening	Active Clinical Patients 18+(see page 19)		

How to determine sample size:

The number of charts you will need to select depends on the number of active patients for **each** specific GPRA measure. Some measures can be grouped together such as: Diabetes Group [Documented A1c, Poor Glycemic Control, Ideal Glycemic Control, Controlled BP, LDL Assessed, and Nephropathy Assessed] and Elder care Group (65+) [Influenza and Pneumovax]. All other measures require the determination of sample sizes separately based on the denominator designation.

Table 2 outlines the minimum number of charts you will need to audit to be reasonably sure (95% Confident) that a 5% difference noted from previous or subsequent audits is a real change and not just due to chance. Please review the following example; [*DV/IPV screening measure*] – If your facility has 200 Active female patients between the ages of 15-40, than you will need to randomly select 132 of those charts and review/document if they have received the appropriate screening within the Report period (see GPRA logic for exact measure definition).

Table 2: Sample Size Calculations

Population (specific to measure)	95% Confidence Level (5% CI) Sample size	Population (specific to measure)	95% Confidence Level (5% CI) Sample size
<30	All	320	175
30	28	340	180
40	36	360	186
50	44	380	191
60	52	400	196
70	59	420	201
80	66	440	205
90	73	460	209
100	79	480	213
110	86	500	217
120	91	525	222
130	97	550	226
140	103	575	230
150	108	600	234
160	113	650	241
170	118	700	248
180	123	750	254
190	127	800	260
200	132	900	269
220	140	1000	278
240	148	2000	322
260	155	3000	341
280	162	4000	350
300	168	5000	357

GPRA Performance Measures and Logic

GPRA DENOMINATOR DEFINITIONS

Report Period: July 1, 2005 – June 30, 2006

Unless noted otherwise in the measure definition, patient age is calculated as of the beginning of the Report Period.

- ***Active Clinical Population for National GPRA Reporting (for Urban Programs Providing Direct Services)***
  - Must have two visits to medical clinics in the past three years.

    At least one visit must be to one of the following core medical clinics:

01	General	06	Diabetic
10	GYN	12	Immunization
13	Internal Medicine	20	Pediatrics
24	Well Child	28	Family Practice
57	EPSDT	70	Women's Health
80	Urgent Care	89	Evening

The second visit can be to either a core clinic or one of the following:

02	Cardiac	32	Postpartum
03	Chest and TB	37	Neurology
05	Dermatology	38	Rheumatology
07	ENT	49	Nephrology
08	Family Planning	50	Chronic Disease
16	Obstetrics	69	Endocrinology
19	Orthopedic	75	Urology
23	Surgical	81	Men's Health Screening
25	Other	85	Teen Clinic
26	High Risk	88	Sports Medicine
27	General Preventive	B8	Gastroenterology - Hepatology
31	Hypertension	B9	Oncology - Hematology

  - Must be alive on the last day of the Report Period.
  - Must be American Indian/Alaska Native (AI/AN).
  - Must reside in a community assigned to the program.

- ***Active Clinical Population for National GPRA Reporting (for referral programs only)***
  - Must have two referral visits in the 3 years prior to the end of the Report Period
  - Must be alive on the last day of the Report period.
  - Must be American Indian/Alaska Native (AI/AN).
  - Must reside in a community assigned to the program.

- ***GPRA User Population (This definition is only used for the Diabetes Ever measure)***
  - Must have been seen at least once in the three years prior to the end of the time period, regardless of the clinic type.
  - Must be alive on the last day of the Report Period.
  - Must be American Indian/Alaska Native (AI/AN)
  - Must reside in a community assigned to the program.

Performance Measure	Definition

Performance Measure	Definition
Diabetes Prevalence	**Denominator:** GPRA User Population patients. **Numerators:** Anyone diagnosed with diabetes (POV 250.00-250.93) ever.
Diabetes: Hemoglobin A1c Measured	**Denominator:** Active Diabetic patients, defined as all Active Clinical patients diagnosed with diabetes (POV 250.00-250.93) prior to the Report Period, AND at least 2 visits in the past year, AND 2 DM-related visits ever. **Numerator:** Patients with hemoglobin A1c documented during the Report Period, regardless of result. **Numerator Logic: A1c:** CPT 83036, LOINC taxonomy for A1c, or local laboratory taxonomy for A1c test; count most recent A1c during the Report Period, regardless of result.
Diabetes: Poor Glycemic Control	**Denominator:** Active Diabetic patients, defined as all Active Clinical patients diagnosed with diabetes (POV 250.00-250.93) prior to the Report Period, AND at least 2 visits in the past year, AND 2 DM-related visits ever. **Numerator:** Patients with A1c greater than (>) 9.5. **Numerator Logic: A1c:** CPT 83036, LOINC taxonomy or local laboratory taxonomy for A1c test; count most recent A1c during the Report Period with a value >9.5.
Diabetes: Ideal Glycemic Control	**Denominator:** Active Diabetic patients, defined as all Active Clinical patients diagnosed with diabetes (POV 250.00-250.93) prior to the Report Period, AND at least 2 visits in the past year, AND 2 DM-related visits ever. **Numerator:** Patients with A1c less than (<) 7. **Numerator Logic: A1c:** CPT 83036, LOINC taxonomy or local laboratory taxonomy for A1c test; count most recent A1c during the Report Period with a value <7.
Diabetes: Ideal Blood Pressure Control	**Denominator:** Active Diabetic patients, defined as all Active Clinical patients diagnosed with diabetes (POV 250.00-250.93) prior to the Report Period, AND at least 2 visits in the past year, AND 2 DM-related visits ever. **Numerator:** Patients with controlled BP defined as < 130/80, i.e. with a mean systolic value is less than 130 and the mean diastolic value is less than 80. **Numerator Logic:** Blood Pressure is mean of last 3 Blood Pressures documented on non-ER visits during the Report Period. If 3 BPs are not available, use mean of last 2 non-ER BPs. If a visit contains more than 1 BP, the lowest BP will be used. The mean Systolic value is calculated by adding the last 3 (or 2) systolic values and dividing by 3 (or 2). The mean Diastolic value is calculated by adding the diastolic values from the last 3 (or 2) blood pressures and dividing by 3 (or 2). If the systolic and diastolic values do not BOTH meet the criteria for controlled, then the value is considered not controlled.
Diabetes: Lipids Assessment	**Denominator:** Active Diabetic patients, defined as all Active Clinical patients diagnosed with diabetes (POV 250.00-250.93) prior to the Report Period, AND at least 2 visits in the past year, AND 2 DM-related visits ever. **Numerators:** Patients with LDL completed during the Report Period, regardless of result. **Numerator Logic: LDL:** CPT 83721; LOINC taxonomy; or local laboratory taxonomy for LDL test.

Performance Measure	Definition
Diabetes: Nephropathy Assessment	**Denominator:** Active Diabetic patients, defined as all Active Clinical patients diagnosed with diabetes (POV 250.00-250.93) prior to the Report Period, AND at least 2 visits in the past year, AND 2 DM-related visits ever. **Numerator:** Patients with positive urine protein test or, if urine protein test is negative, any microalbuminuria test, regardless of result, during the Report Period OR with evidence of diagnosis and/or treatment of ESRD at any time. **Numerator Logic:** 1) **Urine Protein:** LOINC taxonomy; local laboratory taxonomy for urine protein OR IF NEGATIVE 2) **Microalbuminuria:** CPT codes 82043, 82044**,** 83518, or 84166 AND 81050; LOINC taxonomy; or local laboratory taxonomy for Microalbuminuria or A/C ratio OR 3) **End Stage Renal Disease:** ANY diagnosis ever of 585.6 or V45.1 or ANY CPT in the range of 90918-90925.
Adult Immunizations: Influenza	**Denominator:** Active Clinical patients ages 65 and older. **Numerator:** Patients with influenza vaccine documented during the Report Period or with documented refusals or not medically indicated in past year. **Numerator Logic:** 1) **Influenza Vaccine: Immunization/CVX codes** 15, 16, 88, or 111; **POV** V04.8, V04.81, V06.6; **CPT Codes** 90655, 90656, 90657-90660, 90724; **ICD Procedure** 99.52 2) **Refusals: Immunization/CVX codes**: 15, 16, 88, or 111
Adult Immunizations: Pneumovax	**Denominator:** Active Clinical patients ages 65 or older. **Numerator:** Patients with Pneumococcal vaccine documented at any time before the end of the Report Period, including documented refusals or not medically indicated in past year. **Numerator Logic:** 1) **Pneumovax Vaccine: Immunization/CVX codes** 33, 100, 109; **POV** V06.6, V03.82, V03.89**; ICD Procedure** 99.55; **CPT Code** 90732, 90669 2) **Refusal of Pneumovax Vaccine:** Immunization/CVX codes 33, 100, 109

Performance Measure	Definition
Cancer Screening: Pap smear rate	**Denominator:** Female Active Clinical patients ages 21 through 64 without a documented history of hysterectomy. **Numerators:** Patients with documented pap smear in past three years or refusal in past year. **Denominator Logic:** Exclude patients with **Hysterectomy:** A) **V Procedure**: 68.4-68.9; B) **POV** 618.5, V67.01, or V76.47; or C) **CPT** 51925, 56308, 58150, 58152, 58200-58294, 58550-54, 58951, 58953-58954, 58956, 59135. **Numerator Logic:** Include patients with 1) **Pap Smear:** A) **POV**: V76.2 Screen Mal Neop-Cervix; V72.31 Routine Gynecological Examination, Pap Cervical Smear as Part of General GYN Exam; V72.32 Encounter for Pap Cervical Smear to Confirm Findings of Recent Normal Smear Following Initial Abnormal Smear, V72.3 Gynecological Examination , Pap Cervical Smear as Part of General Gynecological Exam, Pelvic Exam (old code, to be counted for visits prior to 10/1/04 only), V76.47 Vaginal Pap Smear for Post-Hysterectomy Patients, V76.49 Pap Smear for Women w/o a Cervix; B) **CPTCodes**: 88141-88167, 88174-88175, Q0091 Screening Pap Smear; C) **LOINC** taxonomy or local laboratory taxonomy for pap smear OR 2) **Refusal**
Cancer Screening: Mammogram Rates	**Denominator:** Female Active Clinical patients ages 52 through 64, without a documented bilateral mastectomy or two separate unilateral mastectomies. **Numerator:** Patients with documented mammogram in past two years or refusal in past year. **Denominator Logic:** Exclude patients with 1) **Bilateral Mastectomy**: **CPT**: 19180.50 or 19180 w/modifier 09950 (modifier codes .50 and 09950 indicate bilateral); 19200.50 or 19200 w/modifier 09950; 19220.50 or 19220 w/modifier 09950; 19240.50 or 19240 w/modifier 09950; **ICD Operation codes**: 85.42; 85.44; 85.46; 85.48 2) **Unilateral Mastectomy:** Requires two separate occurrences for either CPT or procedure codes on 2 different dates of service. V CPT: 19180, 19200, 19220, 19240; V Procedures: 85.41, 85.43, 85.45, 85.47 **Numerator Logic:** Include patients with 1) **Mammogram**: A) **V Radiology or V CPT**: 76090, 76091, 76092**,** G0206 (Diagnostic Mammography, Unilateral), G0204 (Diagnostic Mammography, Bilateral), G0202 (Screening Mammography, Bilateral); B) **POV**: V76.11, V76.12; C) **V Procedures**: 87.36, 87.37 OR 2) **Refusal Mammogram: V Radiology Mammogram for CPT** 76090, 76091, 76092, G0206, G0204, G0202.

Performance Measure	Definition
Alcohol Screening (Fetal Alcohol Syndrome (FAS) Prevention)	**Denominator:** Female Active Clinical patients ages 15 to 44 (child-bearing age). **Numerator:** Patients screened for alcohol use, who have alcohol-related diagnoses, or who have received alcohol-related education or counseling during the Report Period, including refusals in the past year. **Numerator Logic:** 1) **Alcohol Screening:** V11.3; V79.1, or problem code 29.1 2) **Alcohol-related Diagnoses:** POV, Current Problem List: 303.*, 305.0*; 291.*; 357.5*; BHS POV 10, 27, 29 3) **Alcohol Education:** "as designated locally OR 4) **Refusal** **Alcohol Health Factors:** The existing Health Factors for alcohol screening are based on the CAGE questionnaire, which as the following four questions: 1. Have you ever felt the need to **C**ut down on your drinking? 2. Have people **A**nnoyed you by criticizing your drinking? 3. Have you ever felt bad or **G**uilty about your drinking? 4. Have you ever needed and **E**ye opener the first thing in the morning to steady your nerves or get rid of a hangover? Based on how many YES answers are received, document Health Factor(s) HF – CAGE 0/4 (all no answers) HF – CAGE 1/4 HF – CAGE 2/4 HF – CAGE 3/4 HF – CAGE 4/4 <u>*Optional Values</u> Level of Severity: Mild/Moderate/ or Severe Quantity: # of drinks daily
Intimate Partner (Domestic) Violence Screening	**Denominator:** Female Active Clinical patients ages 15-40. **Numerator:** Patients screened for or diagnosed with intimate partner (domestic) violence during the Report Period**,** including documented refusals in past year. **Numerator Logic:** 1) **IPV/DV Related Diagnoses:** POV, Problem List 995.80-83, 995.85, V15.41, V15.42, V15.49; POV 43.*, 44.* 2) **IPV/DV Counseling:** POV V61.11 3) **IPV/DV Patient Education and Screening:** As defined locally 4) **Refusal**

<table>
<tr><th>Performance Measure</th><th>Definition</th></tr>
<tr><td>Childhood Weight Control</td><td>
Denominator: Active Clinical Patients 2-5 for whom a BMI could be calculated, broken out by age groups.

Numerator: Patients with a BMI 95% and up.

Denominator Logic: Age: All patients who are between the age of 2 and 5 at the beginning of the Report Period and who do not turn age 6 during the Report Period are included in this measure.

Numerator Logic: BMI: Use the most recent BMI in the Report Period. Calculate BMI at the time the report is run, using NHANES II. A height and weight must be taken on the same day any time during the Report Period. The BMI values for this measure are reported differently than in Obesity Assessment since this age group is children ages 2-6, whose BMI values are age-dependent. The BMI values are categorized as At-risk for Overweight for patients with a BMI between 85-94% and Overweight for patients with a BMI of 95%. Patients whose BMI either is greater or less than the Data Check Limit range shown below should not be included in the report counts for At-risk for Overweight or Overweight.

BMI STANDARD REFERENCE DATA
<table>
<tr><th rowspan="2">Low-High Ages</th><th rowspan="2">Sex</th><th rowspan="2">BMI >= (Overwt)</th><th colspan="2">Data Check Limits</th></tr>
<tr><th>BMI ></th><th>BMI <</th></tr>
<tr><td>2-2</td><td>Male</td><td>18.7</td><td>36.8</td><td>7.2</td></tr>
<tr><td></td><td>Female</td><td>18.6</td><td>37.0</td><td>7.1</td></tr>
<tr><td>3-3</td><td>Male</td><td>18.0</td><td>35.6</td><td>7.1</td></tr>
<tr><td></td><td>Female</td><td>18.1</td><td>35.4</td><td>6.8</td></tr>
<tr><td>4-4</td><td>Male</td><td>17.8</td><td>36.2</td><td>7.0</td></tr>
<tr><td></td><td>Female</td><td>18.1</td><td>36.0</td><td>6.9</td></tr>
<tr><td>5-5</td><td>Male</td><td>18.1</td><td>36.0</td><td>6.9</td></tr>
<tr><td></td><td>Female</td><td>18.5</td><td>39.2</td><td>6.8</td></tr>
</table>
</td></tr>
<tr><td>Tobacco Cessation</td><td>
Denominator: Active Clinical patients identified as current tobacco users prior to the Report Period.

Numerator: Patients who have received tobacco cessation counseling during the Report Period, including documented refusal in past year.

Denominator Logic: Current Tobacco Users:
A) Tobacco-related Diagnoses (POV or active Problem List): 305.1, 305.10-305.12, or V15.82;
B) Dental code 1320
C) Local designation of tobacco user

Numerator Logic: Tobacco Cessation Counseling:
A) Local Patient Education codes or designations
B) Clinic Code 94;
C) Dental Code 1320
D) Refusal of patient education

Tobacco Health Factor
<table>
<tr><td>Ceremonial</td><td>Previous Smokeless</td></tr>
<tr><td>Cessation-Smokeless</td><td>Previous Smoker</td></tr>
<tr><td>Cessation-Smoker</td><td>Smoke Free Home</td></tr>
<tr><td>Current Smokeless</td><td>Smoker In Home</td></tr>
<tr><td>Current Smoker</td><td>Current Smoker & Smokeless</td></tr>
<tr><td colspan="2">Non-Tobacco User</td></tr>
<tr><td colspan="2">Exposure to Environmental Tobacco Smoke</td></tr>
</table>
</td></tr>
</table>

Performance Measure	Definition
Childhood Immunizations	**Denominator:** Patients who are 19-35 months at end of Report period. **Numerator:** Patients who have received the 4:3:1:3:3 combination (i.e. 4 DTaP, 3 Polio, 1 MMR, 3 HiB, 3 Hepatitis B), including refusals, contraindications, and evidence of disease. **Denominator Logic: Age** of the patient is calculated at the end of the report period. **Numerator Logic:** 1) **Dosage and types of immunization definitions:** • 4 doses of DTaP: 1) 4 DTaP/DTP/Tdap; 2) 1 DTaP/DTP/Tdap ad 3 DT; 3) 1 DTaP/DTP/Tdap and 3 each of Diphtheria and Tetanus; 4) 4 DT and 4 Pertussis; 5) 4 Td and 4 Pertussis; or 6) 4 each of Diphtheria, Tetanus, and Pertussis. • 3 doses of Polio: 1) 3 OPV; 2) 3 IPV: or 3) combination of OPV & IPV totaling 3 doses. • 1 dose of MMR: 1) MMR; 2) 1 M/R and 1 Mumps: 3) 1 R/M and 1Measles; or 4) 1 each of Measles, Mumps, and Rubella. • 3 doses of Hep B • 3 doses of HIB • 1 dose of Varicella • If codes for the same immunization are dated within 10 days of each other they are to be considered the same immunization. 2) **Refusals, evidence of disease, and contraindications** for individual immunizations will also count toward meeting the definition, as defined below: • Each immunization must be refused and documented separately. For example, if a patient refused Rubella only, then there must be an immunization, contraindication, or separate refusal for the Measles and Mumps immunizations. • For immunizations where required number of doses is >1, only one refusal is necessary to be counted in the numerator. For example, if there is a single refusal for Hepatitis B, the patient will be included in the numerator. • Evidence of disease will be checked for at any time in the child's life prior to the end of the report period.
Depression Screening	**Denominators:** Active Clinical patients ages 18 and older. **Numerators:** Patients screened for depression or diagnosed with mood disorder at any time during the Report Period, including documented refusals in past year. **Numerator Logic Definitions:** **Depression Screening:** POV V79.0 or problem code 14.1 (screening for depression) or any local codes. **Mood Disorders:** At least two visits during the Report period with POV for: Major Depressive Disorder, Dysthymic Disorder, Depressive Disorder NOS, Bipolar I or II Disorder, Cyclothymic Disorder, Bipolar Disorder NOS, Mood Disorder Due to a General Medical Condition, Substance-induced Mood Disorder, or Mood Disorder NOS. These POV codes are: 296.*, 291.89, 292.84, 293.83, 300.4, 301.13, or 311 or BHS POV 14 or 15. **Screening Refusal:** Any refusal in past year.

Manual Chart Review Sheet

Report Date: **July 1, 2005 – June 30, 2006**
Demographic Data

Audit Date/Auditor Initials _____ Chart Number_____

Date of Birth _____/_____/_____ (MM/DD/YYYY) Age _____ Sex _____(M/F)

ASUFAC Code _____ Community_____

Height (in)_____ Weight (lbs)_____ BMI_____

All Groups	**YES**	**NO**
Diabetes Prevalence: Has this patient been diagnosed w/ Diabetes at any time before the end of the Report period?		
Diabetes Incidence: Has this patient been diagnosed with Diabetes at any time during the Report period?		

Diabetes Group (if applicable)	**YES**	**NO**
Documented HbA1c: Does the patient have a documented HbA1c during the Report period, regardless of result?		
Poor Glycemic Control: Does the patient have an A1c value between 9.5 and 12, during the Report period?		
Ideal Glycemic Control: Does the patient have and A1c value > or = 7.0 but < 8.0, during the Report period?		
Controlled BP: Does the patient have controlled blood pressure (mean systolic <130 and mean diastolic <80), during the Report period?		
LDL Assessed: Does the patient have a completed LDL, during the Report period?		
Nephropathy Assessed: Does the patient have a positive urine protein test, if urine protein was negative, any microalbuminuria test, regardless of result, during the Report period?		
Active Diabetic Population _____		

Adult Immunizations Group (if applicable)	**YES**	**NO**
Influenza 65+: Has the patient had Influenza vaccination documented during the Report period, including refusals or not medically indicated in the past year?		
Pneumovax 65+: Has the patient had Pneumococcal vaccination documented at any time before the end of the Report period, including refusals or not medically indicated in the past year?		
Active Clinical Population 65+ _____		

Cervical Cancer Screening Group (if applicable)	**YES**	**NO**
Pap Smear: Has the patient had a Pap smear documented in the past 3 years, including refusal in the past year?		
Active Female Clinical Population 21-64 _____		

Manual Chart Review Sheet (con't)

Breast Cancer Screening Group (if applicable)	YES	NO
Mammogram: Has the patient had a Mammogram documented in the past 2 years, including refusal in the past year?		
Active Female Clinical Population 52-64 _____		

FAS Screening Group (if applicable)	YES	NO
FAS Screening: Has the patient been screened for alcohol use, who have alcohol-related diagnoses, or who have received alcohol-related education or counseling during the Report period, including refusal in the past year?		
Active Female Clinical Population 15-44 _____		

DV/IPV Screening Group (if applicable)	YES	NO
DV/IPV Screening: Has the patient been screened for or diagnosed with intimate partner (domestic) violence at any time during the Report period, including refusal in the past year?		
Active Female Clinical Population 15-40 _____		

Childhood Weight Control Group (if applicable)	YES	NO
CWC: Does the patient have a BMI > or = 95%? (see BMI chart in logic description)		
Active Clinical Population 2-5 _____		

Tobacco Cessation Group (if applicable)	YES	NO
Tobacco Cessation: Has the patient received tobacco cessation counseling during the Report period, including documented refusal in the past year?		
Active Clinical Population identified as a tobacco user_____		

Depression Screening Group (if applicable)	YES	NO
Depression Screening: Has the patient been screened for depression or diagnosed with mood disorder at any time during the Report period, including refusal in the past year?		
Active Clinical Population 18+ _____		

Childhood Immunization Group (if applicable)	YES	NO
Childhood Immunizations: Has the patient received the 4:3:1:3:3 combination (4 DTap, 3 Polio, 1MMR, 3 HiB, and 3 HepB), including refusals, contraindications, and evidence of disease, during the Report period?		
Active Clinical Population 19-35 months _____		